*(See DD Form 2005 for Privacy Act Statement)*

## MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE

**ASTHMA QUESTIONNAIRE (EXCEPTIONAL FAMILY MEMBER PROGRAM)**

OTSG APPROVED *(Date)*

1. Sponsor's--

| a. Name *(Last, First, MI)* | b. Social security number | c. Rank or grade |
|---|---|---|
| | | |

| 2. Family member's (patient's) name *(Last, First, MI)* | 3. Family member's prefix |
|---|---|
| | |

4. Medications. List all medications the family member is currently taking. Include over-the-counter and herbal medications.

| Medication | Dosage | Frequency (per day) | Medication | Dosage | Frequency (per day) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

5. Has the family member required mechanical ventiliation during the past 3 months? ☐ Yes ☐ No

6. Has the family member been hospitalized for pulmonary disease during the past year? ☐ Yes ☐ No If "Yes", how many times?

7. Has the family member EVER experienced unconsciousness or seizures associated with asthma? ☐ Yes ☐ No

8. Has the family member experienced any psychological adjustment problems related to his or her asthma during the past year? ☐ Yes ☐ No

8a. If you answered "Yes" to question 8, please describe:

9. Has the family member taken oral steriods during the past year? ☐ Yes ☐ No If "Yes", how many times?

10. Has the family member required an Emergency Room visit for an acute asthma episode during the past year? ☐ Yes ☐ No
If "Yes", how many times?

11. Does anyone else living in the home smoke? ☐ Yes ☐ No

12. How many total days has the family member missed school due to asthma related problems (including visits to the physician) during the past 6 months?

*(Continue on reverse)*

| PREPARED BY *(Signature & Title)* | DEPARTMENT/SERVICE/CLINIC | DATE |
|---|---|---|
| | | |

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)*

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

13. How often does asthma disrupt the following activities? (Please insert an "X" or "✓" in the column that most appropriately answers the question in the left-hand column.)

| | 0 | 2 | 4 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|
| **Activity** | Never a problem | 1 or 2 times per year | 3-5 times per year (or more but less than 8) | 8-10 times per year or more | At least monthly | At least weekly | Daily or almost daily |
| Quiet Activity | | | | | | | |
| Vigorous play or sports | | | | | | | |
| School or work attendance | | | | | | | |
| Socialization with friends | | | | | | | |
| Family outings | | | | | | | |
| Sleep | | | | | | | |

| **DO NOT WRITE IN THIS SPACE** | | |
|---|---|---|
| **90.0** | | |
| **91.0** | | |
| **92.0** | | |
| **93.0** | | |
| **94.0** | | |
| **95.0** | | |
| **96.0** | | |
| | | **= SI** |

_____
Signature of health care provider

_____
Printed name

_____ _____
Civilian or DSN telephone number Date